

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0027961</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Nokomis Golden Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>505 Stevens</u> <u>Nokomis</u> <u>62075</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Montgomery</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(217) 5637725</u> Fax # <u>(217) 563-2022</u>		Paid Preparer (Signed) <u>Compilation Report Attached</u> _____ (Date) _____ (Print Name and Title) <u>Cindy A. Tefteller</u> _____ (Firm Name & Address) <u>C.J. Schlosser & Company, L.L.C.</u> _____ <u>233 East Center Drive, Alton, IL 62002</u> _____ (Telephone) <u>(618) 465-7717</u> Fax # <u>(618) 465-7710</u>																									
IDPA ID Number: <u>37-1128552-1</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>04/01/1983</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Cindy A. Tefteller</u> Telephone Number: <u>(618) 465-7717</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Nokomis Golden Manor# 0027961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>102</u>	Skilled (SNF)	<u>102</u>	<u>37,230</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,230</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,083</u>	<u>218</u>	<u>1,518</u>	<u>3,819</u>	8
9	SNF/PED					9
10	ICF	<u>17,752</u>	<u>9,182</u>		<u>26,934</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,835</u>	<u>9,400</u>	<u>1,518</u>	<u>30,753</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.60%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/01/1983

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 04/01/1983NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 12 and days of care provided 1,518Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Nokomis Golden Manor# 0027961

Report Period Beginning:

01/01/2001

Ending:

12/31/2001**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	113,059	9,492	6,309	128,860	50	128,910		128,910		1
2	Food Purchase		116,716		116,716		116,716	(1,834)	114,882		2
3	Housekeeping	65,759	11,466		77,225		77,225	1,476	78,701		3
4	Laundry	49,636	15,947		65,583		65,583		65,583		4
5	Heat and Other Utilities			78,841	78,841		78,841	654	79,495		5
6	Maintenance	24,411	48,582	794	73,787	3,880	77,667	18,719	96,386		6
7	Other (specify):* <u>Sanitation</u>			4,453	4,453		4,453		4,453		7
8	TOTAL General Services	252,865	202,203	90,397	545,465	3,930	549,395	19,015	568,410		8
	B. Health Care and Programs										
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	998,458	40,311	37,663	1,076,432		1,076,432	(142)	1,076,290		10
10a	Therapy		129	120,137	120,266		120,266		120,266		10a
11	Activities	33,801	3,551	3,363	40,715		40,715		40,715		11
12	Social Services	32,581			32,581		32,581		32,581		12
13	Nurse Aide Training			1,890	1,890	(295)	1,595		1,595		13
14	Program Transportation		1,742		1,742		1,742		1,742		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,064,840	45,733	169,553	1,280,126	(295)	1,279,831	(142)	1,279,689		16
	C. General Administration										
17	Administrative	67,062	10,740	195,000	272,802	(2,093)	270,709	(107,073)	163,636		17
18	Directors Fees										18
19	Professional Services			10,741	10,741		10,741	3,103	13,844		19
20	Dues, Fees, Subscriptions & Promotions			16,736	16,736	957	17,693	(10,945)	6,748		20
21	Clerical & General Office Expenses	51,197	10,983	10,928	73,108	140	73,248	36,468	109,716		21
22	Employee Benefits & Payroll Taxes			186,463	186,463	(3,635)	182,828	13,104	195,932		22
23	Inservice Training & Education					1,000	1,000		1,000		23
24	Travel and Seminar			2,712	2,712	(4)	2,708	184	2,892		24
25	Other Admin. Staff Transportation							1,543	1,543		25
26	Insurance-Prop.Liab.Malpractice			69,513	69,513		69,513	1,966	71,479		26
27	Other (specify):*										27
28	TOTAL General Administration	118,259	21,723	492,093	632,075	(3,635)	628,440	(61,650)	566,790		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,435,964	269,659	752,043	2,457,666		2,457,666	(42,777)	2,414,889		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Nokomis Golden Manor

#0027961

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			88,236	88,236		88,236	(15,383)	72,853			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			32,872	32,872		32,872	634	33,506			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			903	903		903		903			35
36	Other (specify):*											36
37	TOTAL Ownership			122,011	122,011		122,011	(14,749)	107,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,581	1,033	41,614		41,614		41,614			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,845	55,845		55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		40,581	56,878	97,459		97,459		97,459			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,435,964	310,240	930,932	2,677,136		2,677,136	(57,526)	2,619,610			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

0027961

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(167)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,667)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(655)	17		18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,808)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,744)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,271)	21		28
29	Other-Attach Schedule	(26,904)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,616)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(16,910)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,910)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (57,526)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Nokomis Golden Manor

ID# 0027961

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Record 2001 IHCA Dues	\$ 3,079	20	1
2	Eliminate PAC Dues & Other Non-allowable Dues	(872)	20	2
3	Eliminate 2002 IHCA Dues	(5,189)	20	3
4	Straight Line Depr on Items Req'd to be			4
5	Capitalized for Cost Reporting Purposes	(18,876)	30	5
6	Vending Machine Costs	(3,897)	17	6
7	Offset Medical Supplies Refunds	(142)	10	7
8	Eliminate Civic Dues	(35)	17	8
9	Eliminate Promotional Expenses	(45)	17	9
10	Adjust for Deferred Maintenance	92	6	10
11	Eliminate Medicare C/R Settlement	(851)	17	11
12	Offset Maintenance Refunds	(168)	6	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(26,904)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nokomis Golden Manor

0027961

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,834)	0	0	0	0	0	0	0	0	0	0	(1,834)	2
3	Housekeeping	0	1,476	0	0	0	0	0	0	0	0	0	1,476	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	654	0	0	0	0	0	0	0	0	0	654	5
6	Maintenance	(76)	18,795	0	0	0	0	0	0	0	0	0	18,719	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,910)	20,925	0	0	0	0	0	0	0	0	0	19,015	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(142)	0	0	0	0	0	0	0	0	0	0	(142)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(142)	0	0	0	0	0	0	0	0	0	0	(142)	16
	C. General Administration													
17	Administrative	(5,483)	(101,590)	0	0	0	0	0	0	0	0	0	(107,073)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,808)	4,911	0	0	0	0	0	0	0	0	0	3,103	19
20	Fees, Subscriptions & Promotions	(11,126)	181	0	0	0	0	0	0	0	0	0	(10,945)	20
21	Clerical & General Office Expenses	(1,271)	37,739	0	0	0	0	0	0	0	0	0	36,468	21
22	Employee Benefits & Payroll Taxes	0	13,104	0	0	0	0	0	0	0	0	0	13,104	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	184	0	0	0	0	0	0	0	0	0	184	24
25	Other Admin. Staff Transportation	0	1,543	0	0	0	0	0	0	0	0	0	1,543	25
26	Insurance-Prop.Liab.Malpractice	0	1,966	0	0	0	0	0	0	0	0	0	1,966	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(19,688)	(41,962)	0	0	0	0	0	0	0	0	0	(61,650)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,740)	(21,037)	0	0	0	0	0	0	0	0	0	(42,777)	29

Summary B

12/31/2001

[illegible]

Facility Name & ID Number Nokomis Golden Manor# 0027961Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00%	K & G Inc., d/b/a Mt. Vernon Countryside Manor	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00%	King-Taylorville, Inc., d/b/a Taylorville Care Center	Taylorville			
Jerry & Marilyn King	100.00%	Aviston Nursing Center, Inc. d/b/a Countryside Manor	Aviston			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 See Schedule VIII	\$	King Management Co.	100.00%	\$ 1,476	\$ 1,476 1
2	V	5 See Schedule VIII		King Management Co.	100.00%	654	654 2
3	V	6 See Schedule VIII		King Management Co.	100.00%	18,795	18,795 3
4	V	17 See Schedule VIII	195,000	King Management Co.	100.00%	93,410	(101,590) 4
5	V	19 See Schedule VIII		King Management Co.	100.00%	4,911	4,911 5
6	V	20 See Schedule VIII		King Management Co.	100.00%	181	181 6
7	V	21 See Schedule VIII		King Management Co.	100.00%	37,739	37,739 7
8	V	22 See Schedule VIII		King Management Co.	100.00%	13,104	13,104 8
9	V	24 See Schedule VIII		King Management Co.	100.00%	184	184 9
10	V	25 See Schedule VIII		King Management Co.	100.00%	1,543	1,543 10
11	V	26 See Schedule VIII		King Management Co.	100.00%	1,966	1,966 11
12	V	30 See Schedule VIII		King Management Co.	100.00%	3,493	3,493 12
13	V	33 See Schedule VIII		King Management Co.	100.00%	634	634 13
14	Total		\$ 195,000			\$ 178,090	\$ * (16,910) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Nokomis Golden Manor # 0027961 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00%	171,966	15	24.67%	Salary	\$ 56,329	17,8	1
2	Denise King	Regional Director	Administrative	0.00%	103,771	12	24.67%	Salary	33,991	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00%	55,957	12	24.67%	Salary	18,329	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00%	97,630	0	0.00%	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00%	2,400	0	0.00%	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00%	2,260	1	24.67%	Salary	740	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 109,389		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor# 0027961

Report Period Beginning:

01/01/2001Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization King Management CompanyStreet Address 935 South Mill StreetCity / State / Zip Code Nashville, IL 62263Phone Number (618) 327-3064Fax Number (618) 327-3083

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	4	\$ 5,984	\$ 5,984	30,746	\$ 1,476	1
2	5	Utilities	Patient Days	4	2,650		30,746	654	2
3	6	Maintenance	Patient Days	4	76,174	74,286	30,746	18,795	3
4	17	Administrative	Patient Days	4	378,582	369,057	30,746	93,410	4
5	19	Professional Fees	Patient Days	4	19,903		30,746	4,911	5
6	20	Dues, Fees & Subscriptions	Patient Days	4	735		30,746	181	6
7	21	Clerical and Office Expense	Patient Days	4	152,952	118,721	30,746	37,739	7
8	22	Employee Benefits	Patient Days	4	53,108		30,746	13,104	8
9	24	Travel & Seminar	Patient Days	4	745		30,746	184	9
10	25	Other Admin. Staff Transport.	Patient Days	4	6,252		30,746	1,543	10
11	26	Insurance	Patient Days	4	7,969		30,746	1,966	11
12	30	Depreciation-Other	Patient Days	4	8,640		30,746	2,132	12
13	30	Depreciation-Autos	Patient Days	4	5,518		30,746	1,361	13
14	30	Depreciation-Autos	Direct Cost	1	969		N/A		14
15	30	Depreciation-Copier	Direct Cost	1	1,038		N/A		15
16	33	Property Taxes	Patient Days	4	2,571		30,746	634	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 723,790	\$ 568,048		\$ 178,090	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Schedule Not Applicable						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Nokomis Golden Manor**# **0027961** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 31,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 31,547	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (253)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 33,125	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 32,872	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 27,915	8	
	1997 28,559	9	
	1998 28,577	10	
	1999 30,269	11	
	2000 31,547	12	
Line 2: Real Estate Tax Payment was for 2000 tax year	Line 7: \$32,872 Real Estate Tax		
Line 4: Accrual is based on 2000 taxes paid	634 Home Office Allocation		
	\$33,506 Total Real Estate Tax		
		FOR OHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nokomis Golden Manor COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0027961

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-000-551-51</u>	<u>10-2-188A-1</u>	\$ <u>31,414.52</u>	\$ <u>31,414.52</u>
2. <u>10-000-188-05</u>	<u>10-2-188A-1</u>	\$ <u>132.78</u>	\$ <u>132.78</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>31,547.30</u></u>	\$ <u><u>31,547.30</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 32,807
 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
Section Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	217,800	1983	\$ 10,000	1
2	Home Office		1989	1,552	2
3	TOTALS	217,800		\$ 11,552	3

Facility Name & ID Number Nokomis Golden Manor

0027961

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1970	1970	\$ 466,571	\$ 25,277	26	\$ 5,138	\$ (25,277)	\$ 466,571	4
5	25		1975	1975	205,532		40	5,138	5,138	138,734	5
6	7		1984	1984	45,669		40	1,142	1,142	20,551	6
7	8		1987	1987	104,200	3,872	30	3,473	(399)	52,100	7
8	8		1994	1994	225,527	7,777	40	5,638	(2,139)	44,652	8
	Improvement Type**										
9	Various Improvements			1974	2,187		25			2,182	9
10	Various Improvements			1980	1,617		25	65	65	1,423	10
11	Morton Building			1982	22,363		20	1,118	1,118	22,316	11
12	Fire Doors			1986	2,092	37	10		(37)	2,092	12
13	Smoke Detectors			1986	446	10	10		(10)	446	13
14	Floor Covering			1986	3,700		10			3,700	14
15	Roof			1986	8,940		10			8,940	15
16	Sprinkler System			1987	11,964		10			11,964	16
17	Boiler Tubes			1987	4,880		10			4,880	17
18	Roof			1988	58,230	1,456	40	1,456		20,017	18
19	Stainless Steel Fire Shutters			1988	4,385	110	40	110		1,471	19
20	15 Ton Carrier Condensing			1989	6,500		10			6,500	20
21	Painting & Wallpapering			1986	1,557		10			1,261	21
22	Nurse Station Monitors			1992	3,345	334	10	334		3,204	22
23	Nurse Station Counters			1992	7,155	477	15	477		4,333	23
24	Grease Trap			1992	2,425	243	10	243		2,284	24
25	3 Ton Air Conditioner			1992	2,600		5			2,600	25
26	Nurse Call Station			1993	22,218	1,481	15	1,481		12,343	26
27	Air Cleaners, Heaters			1993	3,838	256	15	256		2,133	27
28	New Road			1994	3,624		5			3,624	28
29	Kick Plates for Doors			1994	2,785	279	10	279		1,950	29
30	Walk in Cooler with Ramp			1996	4,656	310	15	310		1,732	30
31	Three Door Freezer			1996	3,846	256	15	256		1,431	31
32	New Addition - Offices, Activities, Social Services			1996	164,964	6,110	27	6,110		33,095	32
33	Flooring - New Addition			1996	1,368	137	10	137		741	33
34	Lighting - New Addition			1996	1,337	89	15	89		483	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

01/01/2001 Ending: 12/31/2001

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,603,324	\$ 71,174		\$ 50,775	\$ (20,399)	\$ 933,325	1
2	Air Conditioner	2001	6,014	301	10	301		301	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15	Home Office Parking Lot	1989	488					488	15
16	Home Office New Building	1995	24,187		25	967	967	5,966	16
17	Home Office Interior Finishes	1996	1,500		15	100	100	550	17
18	Home Office Carpet	1996	525		5	53	53	525	18
19	Home Office Cabinets	1996	830		20	41	41	228	19
20	Home Office Electrical	1996	287		15	19	19	105	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,637,155	\$ 71,475		\$ 52,256	\$ (19,219)	\$ 941,488	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 92,967	\$ 9,287	\$ 11,468	\$ 2,181	5-10	\$ 55,971	71
72	Current Year Purchases	23,528	1,372	1,666	294	5-10	1,666	72
73	Fully Depreciated Assets	239,240					239,240	73
74								74
75	TOTALS	\$ 355,735	\$ 10,659	\$ 13,134	\$ 2,475		\$ 296,877	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1998 Ford E350 Van	1998	\$ 24,406	\$ 6,102	\$ 6,102		4	\$ 19,830	76
77	Home Office Vehicle	1998 Ford F150 Truck	1997	6,535		1,361	1,361	4	6,535	77
78										78
79										79
80	TOTALS			\$ 30,941	\$ 6,102	\$ 7,463	\$ 1,361		\$ 26,365	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,035,383	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,236	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,853	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,383)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,264,730	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ N/A YES ☐ N/A NO

16. Rental Amount for movable equipment: \$ 903

Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Section Not Applicable</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input checked="" type="checkbox"/>	IN OTHER FACILITY <input checked="" type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	145	\$	145
2	Books and Supplies		50		50
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		1,400		1,400
8	Nurse Aide Competency Tests				
9	TOTALS	\$	1,595	\$	1,595
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,595		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,914	\$ 35,609	\$	1,914	\$ 35,609	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		519	14,684		519	14,684	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,450	69,844	129	3,450	69,973	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				40,581		40,581	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Lab, X-Ray & Other (specify): Ambulance	39,3					1,033		1,033	13
14	TOTAL			\$	5,883	\$ 120,137	\$ 41,743	5,883	\$ 161,880	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 316,022	\$	1
2	Cash-Patient Deposits	2,322		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,452)	455,699		3
4	Supply Inventory (priced at cost)	4,370		4
5	Short-Term Investments	300,552		5
6	Prepaid Insurance	7,025		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,085,990	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,645		13
14	Buildings, at Historical Cost	1,969,098		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	269,440		16
17	Accumulated Depreciation (book methods)	(1,190,756)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Constr. In Progress	4,846		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,078,273	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,164,263	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 64,941	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,322		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,810		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,209		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,125		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 215,407	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 215,407	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,948,856	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,164,263	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,755,954	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,755,954	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	417,902	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(225,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 192,902	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,948,856	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,781,215	1
2	Discounts and Allowances for all Levels	122,442	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,903,657	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	169,370	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 169,370	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	126	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,135	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,135	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Diaper Charges</u>	800	28
28a	<u>Miscellaneous Income</u>	9,950	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,750	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,095,038	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	545,465	31
32	Health Care	1,280,126	32
33	General Administration	632,075	33
B. Capital Expense			
34	Ownership	122,011	34
C. Ancillary Expense			
35	Special Cost Centers	41,614	35
36	Provider Participation Fee	55,845	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,677,136	40
41	Income before Income Taxes (line 30 minus line 40)**	417,902	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 417,902	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Nokomis Golden Manor**# **0027961**Report Period Beginning: **01/01/2001**

Ending:

12/31/2001**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,824	2,217	\$ 45,469	\$ 20.51	1
2	Assistant Director of Nursing	1,853	1,954	36,723	18.79	2
3	Registered Nurses	7,372	7,868	125,634	15.97	3
4	Licensed Practical Nurses	16,161	16,968	229,709	13.54	4
5	Nurse Aides & Orderlies	66,321	69,757	560,923	8.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,940	4,210	33,801	8.03	10
11	Social Service Workers	3,406	3,764	32,581	8.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,673	16,960	113,059	6.67	15
16	Dishwashers					16
17	Maintenance Workers	2,049	2,094	24,411	11.66	17
18	Housekeepers	8,320	9,133	65,759	7.20	18
19	Laundry	8,033	8,306	49,636	5.98	19
20	Administrator	1,832	2,314	67,062	28.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,788	4,049	51,197	12.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,572	149,594	\$ 1,435,964 *	\$ 9.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	174	\$ 6,309	1,3	35
36	Medical Director	Contract	6,500	9,3	36
37	Medical Records Consultant	13	846	10,3	37
38	Nurse Consultant	Contract	450	10,3	38
39	Pharmacist Consultant	Contract	900	10,3	39
40	Physical Therapy Consultant	Contract	6,405	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	58	3,363	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	245	\$ 24,773		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 300	10,3	50
51	Licensed Practical Nurses	151	4,631	10,3	51
52	Nurse Aides	1,388	24,131	10,3	52
53	TOTAL (lines 50 - 52)	1,547	\$ 29,062		53

SEE ACCOUNTANTS' COMPILATION REPORT

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Heating/Air Cond.	3/98	\$ 1,673	3	\$ 465	\$ 558	\$ 558	\$ 92	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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12													
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16													
17													
18													
19													
20	TOTALS		\$ 1,673		\$ 465	\$ 558	\$ 558	\$ 92	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Nokomis Golden Manor

STATE OF ILLINOIS

0027961

Report Period Beginning: 01/01/2001

Page 23

Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc. - \$3,819
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,624 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 53%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

NOKOMIS GOLDEN MANOR
RECLASSIFICATIONS
12/31/01

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
SEMINARS & TRAVEL	24	996
CLERICAL & GENERAL OFFICE EXPENSE	21	140
FEES & SUBSCRIPTIONS	20	957
ADMINISTRATIVE	17	(2,093)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	\$324	
SUBSCRIPTIONS	278	
SEMINAR	996	
OTHER DUES & LICENSES	355	
FRANCHISE TAX	140	
TOTAL	<u>\$2,093</u>	
MAINTENANCE	6	3,880
EMPLOYEE BENEFITS	22	(3,880)
TO RECLASS UNIFORM EXPENSE TO CORRECT DEPARTMENTS		
DIETARY	1	50
EMPLOYEE BENEFITS	22	245
NURSES AIDE TRAINING	13	(295)
TO RECLASS EXPENSES TO THE CORRECT LINES		
INSERVICE TRAINING & EDUCATION	23	1,000
SEMINARS	24	(1,000)
TO RECLASS TRAINING TO THE CORRECT LINE		

Nokomis Golden Manor
Provider #0027961
Attachment to Schedule XIII, Part A
12/31/2001

The following facility trained our aides:

Heritage Manor of Pana	Pana, IL	\$350 per aide
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KING MANAGEMENT, INC. D/B/A NOKOMIS GOLDEN MANOR
IDPH ID #0027961
ATTACHMENT TO SCHEDULE XVII, LINE 28a
12/31/01

OTHER REVENUE:

VENDING INCOME	\$1,849
SODA INCOME	5,670
REBATES & REFUNDS	310
PRIVATE PAY REVENUE	1,597
NURSE AIDE TRAINING REIMBURSEMENT	303
MISCELLANEOUS	221
	<hr/>
	9,950
	<hr/>

NOKOMIS GOLDEN MANOR
ATTACHMENT TO SCHEDULE XIX, SECTION G
12/31/2001

NAME OF PERSONS ATTENDING	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST
Patsy Clavin	Social Services	3/7/2001	Springfield	SSPI 6th Annual Convention - Our Care is Timeless	SSPI	72
Pacie Epley	Social Services	3/7/2001	Springfield	SSPI 6th Annual Convention - Our Care is Timeless	SSPI	72
Denise King	Regional Director	4/10/2001	Springfield	Assisted Living Symposium	IHCA	110
Marilyn Goggans	Administrator	4/10/2001	Springfield	Assisted Living Symposium	IHCA	85
Judy Marley	DON	5/23/2001	Springfield	Pain Management in the New Millennium: Fact and Fiction	IHCA	85
Shawndra Smith	ADON	5/23/2001	Springfield	Pain Management in the New Millennium: Fact and Fiction	IHCA	65
Susan Collman	Administrator	5/23/2001	Springfield	Pain Management in the New Millennium: Fact and Fiction	IHCA	65
Judy Marley	DON	6/21/2001	Bloomington	A Vision for the Future	IALTCO	20
Susan L. Collman	Administrator	8/1/2001	Springfield	Changing Traditions in Long-Term Care	IHCA	85
Judy Marley	DON	8/1/2001	Springfield	Changing Traditions in Long-Term Care	IHCA	65
Shawndra Smith	ADON	8/1/2001	Springfield	Changing Traditions in Long-Term Care	IHCA	65
Marcia Pilgrim	Activities	8/14/2001	Springfield	Beyond the Basics II: achieving excellence in activities	OSI	63
Sharon Braden	Activities	8/14/2001	Springfield	Beyond the Basics II: achieving excellence in activities	OSI	68
Susan Collman	Administrator	10/25/2001	Springfield	Clinical Issues in Infection Control	IHCA	85
Shawndra Smith	DON	10/25/2001	Springfield	Clinical Issues in Infection Control	IHCA	65
Susie Witt	ADON	10/25/2001	Springfield	Clinical Issues in Infection Control	IHCA	65
Susan Collman	Administrator	10/10/2001	Mt. Vernon	MDS... by the Book	IHCA	85
Becky Schweiger	Medicare Coord.	10/11/2001	Springfield	MDS... by the Book	IHCA	65
Shawndra Smith	DON	11/14/2001	St. Louis, MO	Chronic Wound Management: Striving for Better Outcomes More Cost-Effectively	3M Health Care	40
Susie Witt	ADON	11/14/2001	St. Louis, MO	Chronic Wound Management: Striving for Better Outcomes More Cost-Effectively	3M Health Care	40
Marcia Pilgrm	Activities	10/4-10/5	Decatur	Activity Convention	IAPA	150
Sharon Braden	Activities	10/4-10/5	Decatur	Activity Convention	IAPA	150
				IHCA Convention	IHCA	996
				Miscellaneous Seminar Travel Expenses		47
						<u>2,708</u>